Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
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Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 11, 2021	2021_882760_0019	002689-21, 003955-21, 005486-21, 005808-21, 006917-21	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
Seniors Services and Long-Term Care (Union Station) c/o 55 John Street Toronto ON M5V 3C6

Long-Term Care Home/Foyer de soins de longue durée

Seven Oaks
9 Neilson Road Scarborough ON M1E 5E1

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JACK SHI (760)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 7, 8, 9, 10, 2021.

The following intakes were completed in this critical incident inspection:

A log was related to an allegation of improper treatment of a resident;
Four logs were related to falls.

During the course of the inspection, the inspector(s) spoke with the Building Service Manager (BSM), essential caregivers, the Social Worker (SW), Registered Nurses (RN), Registered Practical Nurses (RPN), a Behavioural Supports Ontario Personal Support Worker (BSO PSW), Personal Support Workers (PSW), Nurse Managers (NM), the Administrator and the Director of Care (DOC).

During the course of the inspection, the inspector toured the home, observed Infection Prevention and Control (IPAC) practices, observed care activities on the units, reviewed relevant policies and procedures and reviewed resident records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe environment related to infection prevention and control measures specified in Directive #3.

The Chief Medical Officer of Health (CMOH) implemented Directive #3, which has been

issued to Long-Term Care Homes (LTCHs), and sets out specific precautions and procedures that homes must follow to protect the health of residents and address the risks of an outbreak of COVID-19 in LTCHs. As part of this directive, dated May 22, 2021, the following has been issued to Long-Term Care Homes:

- All staff and essential visitors are required to wear eye protection when they are within 2 metres of a resident.
- Physical distancing must be practiced at all times.
- All staff and visitors must always comply with universal masking requirements.
- Homes are to have in place policies and procedures related to Infection Prevention and Control (IPAC) practices.

The following observations were made during the course of the inspection at the home:
• One RPN, the BSO PSW, one visitor, the social worker, two PSWs were seen in direct contact and/or providing direct care to a resident and did not wear any eye protection. The DOC stated that the expectation was when they are in close contact and cannot maintain physical distance, they need their eye protection on.
• An RPN and a visitor was seen in a resident unit and their mask was noted to not have covered their nose.
• A PSW was seen without wearing a gown when they entered a resident's room that had contact/droplet precautions. The PSW donned on a gown after the inspector spoke with the PSW. The administrator stated that anyone on contact/droplet precautions, needs to have the required PPE donned on.
• The inspector witnessed five staff members coming out of the elevator and onto a resident unit. A Nurse Manager (NM) stated that to ensure physical distancing was maintained, only three people are allowed at one time.
• An RPN was seen wearing two masks; a clothed mask and a surgical mask to cover their clothed mask. The NM said that this did not align with the home's IPAC program and a surgical mask should not have been worn over their clothed mask.
• A PSW was seen with a disposable coffee cup placed on their resident care cart. The PSW stated they were not supposed to have their coffee cup placed on their care cart and they discarded the cup. The DOC stated that disposable coffee cups are not to be placed on care carts because it may cause possible contamination with the clean linens placed on it.

The observations demonstrated that that there were inconsistent IPAC practices from the staff and visitors of the home. There was actual risk of harm to residents associated with these observations because by not adhering to the home's IPAC program and the

measures set out in Directive #3, there could be possible transmission of infectious agents.

Sources: Directive #3, dated May 22, 2021; Interviews with three RPNs, the Administrator, a Social Worker, the BSO PSW, four PSWs, two essential caregivers, two Nurse Mangers, the DOC and other staff; Observations made throughout the home during the inspector's inspection. [s. 5.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident’s care plan was followed related to the use of a fall prevention intervention.

The resident’s most current care plan states that a fall prevention intervention was to be used with the resident. An observation with the resident demonstrated that this intervention was not put in place. The PSW confirmed that they did not apply this fall prevention intervention and was aware that it was part of this resident's plan of care. There was potential risk of harm to the resident, as the failure to apply a fall prevention intervention may risk further injury to the resident, if they fell.

Sources: A resident’s care plan; Observation made with the resident; Interviews with a PSW and other staff. [s. 6. (7)]

2. The licensee failed to ensure that the care set in a resident's plan of care was followed by a PSW.

According to the resident’s progress notes, the resident sustained a fall during the provision of care from a PSW. The resident sustained injuries and required further medical interventions. At the time of this incident, the resident’s care plan stated that they needed a certain requirement for staff during the provision of care. The home's investigation notes and an interview with the Nurse Manager (NM) confirmed that the PSW involved in this incident did not follow this resident's plan of care, as it related to their requirement for staff during the provision of their care. There was actual harm to the resident, as the failure to follow the resident's plan of care during the provision of their care resulted in a fall with a diagnosed injury.

Sources: Interviews with the NM and other staff; a resident's progress notes and care plan; Home’s investigation notes. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that a PSW and RN used safe transferring techniques following the fall of a resident.

According to the progress notes, the resident sustained a fall with an injury and required further medical interventions. The home has a no lift policy as it relates to their practice and procedures. The RN and PSW stated in their interviews that they had performed a transfer with the resident following their fall. A NM stated that the staff that the transfer performed by the RN and PSW was unsafe and may have further aggravated the resident's injury.

Sources: A resident’s progress notes; Home’s policy, titled “No Lift Policy”, dated January 2015; Interviews with an RN, a PSW, the NMand other staff. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature was measured and documented in one resident common area on every floor of the home, between a period of time.

Seven Oaks is a long-term care home with five resident floor units. A review of the home's air temperature monitoring records indicated that between a period of time, one temperature reading was being taken in one common area of the home. An interview with the Building Service Manager (BSM) indicated that the home had recently switched to a new temperature monitoring log to allow documentation of different resident floor units. Previously, the home did not take readings in every floor area of the home.

Sources: Review of temperature readings from the home during a period of time; Interview with BSM. [s. 21. (2) 2.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the names of all staff members involved in a resident's fall was included in the CIS report.

A CIS report was submitted to the Director related to a fall that the resident sustained and resulted in injuries and their hospitalization. An interview with a PSW indicated they were involved in the resident's fall. The NM confirmed that there were no PSWs named in the CIS report and that the names of all staff members should be in a CIS report.

Sources: Review of a CIS report; Interview with a PSW, the NM and other staff. [s. 107. (4) 2. ii.]

Issued on this 11th day of June, 2021

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JACK SHI (760)
Inspection No. / No de l'inspection :	2021_882760_0019
Log No. / No de registre :	002689-21, 003955-21, 005486-21, 005808-21, 006917-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 11, 2021
Licensee / Titulaire de permis :	City of Toronto Seniors Services and Long-Term Care (Union Station), c/o 55 John Street, Toronto, ON, M5V-3C6
LTC Home / Foyer de SLD :	Seven Oaks 9 Neilson Road, Scarborough, ON, M1E-5E1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Peter Puiatti

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To City of Toronto, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee must be compliant with s. 5 of the Long-Term Care Homes Act (LTCHA).

Specifically, the licensee must:

1. Conduct monitoring in all home areas to ensure staff are adherent to the appropriate Infection Prevention and Control (IPAC) practices.

2. Provide on the spot education and training to staff and/or visitors not adhering with appropriate IPAC measures.

Grounds / Motifs :

1. The licensee has failed to ensure that the home was a safe environment related to infection prevention and control measures specified in Directive #3.

The Chief Medical Officer of Health (CMOH) implemented Directive #3, which has been issued to Long-Term Care Homes (LTCHs), and sets out specific precautions and procedures that homes must follow to protect the health of residents and address the risks of an outbreak of COVID-19 in LTCHs. As part of this directive, dated May 22, 2021, the following has been issued to Long-Term Care Homes:

- All staff and essential visitors are required to wear eye protection when they are within 2 metres of a resident.
- Physical distancing must be practiced at all times.
- All staff and visitors must always comply with universal masking requirements.
- Homes are to have in place policies and procedures related to Infection

Prevention and Control (IPAC) practices.

The following observations were made during the course of the inspection at the home:
• One RPN, the BSO PSW, one visitor, the social worker, two PSWs were seen in direct contact and/or providing direct care to a resident and did not wear any eye protection. The DOC stated that the expectation was when they are in close contact and cannot maintain physical distance, they need their eye protection on.
• An RPN and a visitor was seen in a resident unit and their mask was noted to not have covered their nose.
• A PSW was seen without wearing a gown when they entered a resident's room that had contact/droplet precautions. The PSW donned on a gown after the inspector spoke with the PSW. The administrator stated that anyone on contact/droplet precautions, needs to have the required PPE donned on.
• The inspector witnessed five staff members coming out of the elevator and onto a resident unit. A Nurse Manager (NM) stated that to ensure physical distancing was maintained, only three people are allowed at one time.
• An RPN was seen wearing two masks; a clothed mask and a surgical mask to cover their clothed mask. The NM said that this did not align with the home's IPAC program and a surgical mask should not have been worn over their clothed mask.
• A PSW was seen with a disposable coffee cup placed on their resident care cart. The PSW stated they were not supposed to have their coffee cup placed on their care cart and they discarded the cup. The DOC stated that disposable coffee cups are not to be placed on care carts because it may cause possible contamination with the clean linens placed on it.

The observations demonstrated that that there were inconsistent IPAC practices from the staff and visitors of the home. There was actual risk of harm to residents associated with these observations because by not adhering to the home's IPAC program and the measures set out in Directive #3, there could be possible transmission of infectious agents.

Sources: Directive #3, dated May 22, 2021; Interviews with three RPNs, the Administrator, a Social Worker, the BSO PSW, four PSWs, two essential caregivers, two Nurse Mangers, the DOC and other staff; Observations made

throughout the home during the inspector's inspection

Severity: There was actual risk of harm to the residents because of the risk of transmitting infectious diseases when the staff and visitors are not adhering to the appropriate measures stated within Directive #3 and staff not participating in the implementation of the IPAC program.

Scope: The scope of this non-compliance was widespread because the IPAC related concerns and the non-adherence to the measures stated within Directive #3 were identified from multiple observations conducted throughout the LTCH. The non-compliance has the potential to affect a large number of the LTCH's residents.

Compliance History: Multiple WNs and VPCs were issued to the home related to different sub-sections of the legislation in the past 36 months (760)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 21, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 11th day of June, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jack Shi

Service Area Office /
Bureau régional de services : Central East Service Area Office